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Substance, structure and stigma: Parents in the UK accounting for opioid substitution therapy during the antenatal and postnatal periods

Abstract

Background: Parenting and pregnancy in the context of drug use is a contentious topic, high on the policy agenda. Providing effective support to parents who are opioid dependent, through early intervention, access to drug treatment and parenting skills training, is a priority. However, little is known about opioid dependent parents' experiences and understanding of parenting support during the antenatal and postnatal periods. This paper focuses on the position and impact of opioid substitution therapy (OST) in the accounts of parents who were expecting, or who had recently had, a baby in the UK.

Methods: Semi-structured qualitative interviews were held with a purposive sample of 19 opioid dependent service users (14 female, 5 male). Longitudinal data was collected across the antenatal and postnatal (up to 1 year) periods, with participants interviewed up to three times. Forty-five interviews were analysed thematically, using a constant comparison method, underpinned by a sociologically informed narrative approach.

Results: Participants' accounts of drug treatment were clearly oriented towards demonstrating that they were doing 'the best thing' for their baby. For some, OST was framed as a route to what was seen as a 'normal' family life; for others, OST was a barrier to such normality. Challenges related to: the physiological effects of opioid dependence; structural constraints associated with treatment regimes; and the impact of negative societal views about drug-using parents.

Conclusion: Parents' accounts of OST can be seen as a response to socio-cultural ideals of a 'good', drug-free parent. Reflecting the liminal position parents engaged in OST found themselves in, their narratives entailed reconciling their status as a 'drug-using parent' with a view of an 'ideal parent' who was abstinent.

Key words: methadone maintenance treatment, opioid substitution therapy, parenting, pregnancy

Introduction

Parental drug misuse is recognised as an important concern with regard to child welfare (ACMD, 2003; HM Government, 2010; The Scottish Government, 2008). Policy in the UK recommends parenting interventions – particularly those that involve early intervention, access to drug treatment and ‘whole family’ approaches (Cabinet Office, 2008; HM Government, 2010). However, with some exceptions, evidence remains scarce regarding how effective parenting interventions are for substance using mothers and fathers in the UK (Forrester et al., 2008; Niccols et al., 2012; Templeton, 2012). Similarly, little is known regarding parents’ views of substance use services more broadly, and how they might support or hinder their parenting practices. In particular, what constitutes ‘parenting support’ is rarely examined from the perspective of drug-using parents themselves.

This paper contributes to a growing literature discussing the role of Opioid Substitution Therapy (OST) in the context of parenthood (Banwell, 2003; Banwell & Bammer, 2006; Leppo, in press; Radcliffe, 2011; Richter & Bammer, 2000). Our approach maintains the importance of wider social contexts and processes in mediating the ability of drug-using parents to be ‘good-enough’ (Rhodes et al., 2010). Such contexts include the provision and use of health and social care services. With some exceptions (Lund et al., 2012; Rhodes et al., 2010), many existing studies have focused upon the accounts of mothers. These have highlighted the problems encountered when attempting to maintain an identity as a ‘good mother’ in the face of wider societal views which frame any drug use (including OST) as incompatible with mothering (Reid et al., 2008). OST represents a possible strategy for drug-using mothers to reduce potential harm to children (Hogan & Higgins, 2001; Richter & Bammer, 2000). However, work by Banwell (2003) has demonstrated the intensely ambivalent nature of OST for mothers: while OST was in some cases described as helping women to engage in ‘normal’ family life; conversely it tied the user to a stigmatised, deviant identity. Further, participants highlighted ways in which OST obstructed their daily lives: through troubling bodily symptoms such as excessive sweating or fatigue; to having to organise life around daily prescription collection.

The management of illicit drug use around parenting has been explored in a number of studies. These highlight a range of strategies through which parents seek to minimise harm to children (Hogan, 2003; Klee, 1998; Rhodes et al., 2010; Richter & Bammer, 2000). As well as entering drug-treatment, this can include attempting to hide drug use from children; ensuring that children’s basic needs are met before attending to drug use; and using different types of drugs (e.g. cannabis) to manage withdrawal symptoms and continue to provide care. Such studies emphasise the morally charged character of parental accounts of drug use. This is evident in Rhodes et al (2010) on the accounts of drug-using parents regarding the harm or damage drug use might pose to children. Participants in the study were largely current users of illicit drugs, and their accounts addressed harm in different ways: accepting, qualifying or resisting the extent to which their own drug use had caused harm to their children. Frequently participants ‘shifted between’ these different types of accounts, and Rhodes et al suggested there is a need for services to facilitate opportunities for drug-using parents to talk about parenting and family life, and for the creation of wider ‘enabling

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environments' to encourage earlier help seeking, so that harm reduction approaches could focus upon families and relationships, rather than individual drug users (2010: p. 1496-7).

The time around the birth of a baby is frequently framed as a 'crucial' point at which interventions may be particularly efficacious, and when substance using mothers in particular might be particularly motivated to 'turn around' their lives (Hall & van Teijlingen, 2006; Klee et al., 2002; Radcliffe, 2011). However, longitudinal research that is able to examine these changes over time has been limited. Studies that have used longitudinal approaches have highlighted the importance of social support (both from services and interpersonal networks) in shaping substance use and parenthood trajectories (Klee et al., 2002; Lund et al., 2012; Radcliffe, 2011). Research carried out by Skinner and colleagues (2010) in the US that used long-term follow up reported poor outcomes for drug dependent parents and their children. These findings highlight the complex and enduring contexts of disadvantage in which much drug dependence occurs, with Skinner et al reporting that of the 130 families they located after 12 years, 24% of the drug dependent parents had died; and of those still surviving, 52% were unemployed and 54% had been incarcerated in the previous 10 years. They concluded that both parents and children would likely require extra support in order to attempt to counter such negative outcomes.

The research reported upon here examined the ways in which drug-dependent parents accounted for their experiences of both parenting and parenting support, with a focus on the antenatal and postnatal periods. In particular we examined the narratives parents generated regarding the impact of problem drug use, including use of OST, on parenting.

Methods

This study was carried out in Scotland, and comprised a qualitative exploration of service user and service provider accounts of the provision of parenting support for drug-using parents during the antenatal and postnatal periods. This paper reports on the service user data only. Service users were recruited through NHS services in South East Scotland, a location incorporating several densely populated urban centres with surrounding rural areas. We aimed to recruit participants during their or their partners', pregnancy, with the first of three longitudinal interviews planned at around week 28 of the pregnancy. Subsequent interviews were planned at 2-3 months and 6-9 months postnatal. The timing of the interviews was designed to coincide with times where services might be expected to alter or intensify. Additionally, carrying out repeat interviews with participants across approximately one year enabled analysis of the ways in which narratives might alter over time in response to changing parenting needs and often rapidly changing life circumstances (e.g. the birth of a child; child protection involvement; a relapse). A purposive sampling strategy was used, designed to maximise diversity within the sample and the comparative potential of the data. We sought to include male and female participants, both younger (under 25) and older (over 25) parents; first-time and experienced parents; injectors and non-injectors, and those with different patterns of service use.

Recruitment and Sample

Although recruitment was challenging, we interviewed nineteen service users, five men and fourteen women (not couples, therefore participants were from different families). While we had hoped to use snowball sampling to recruit parents who were not using services, this approach was unsuccessful, resulting in our sample being comprised only of people engaged in OST, although some

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were recent attenders. Of the nineteen participants, we interviewed ten at all three stages (three men, seven women) with seventeen interviewed on at least two occasions. A total of seventeen antenatal and twenty-eight postnatal interviews were conducted. Participants were offered a £20 voucher for each interview to cover expenses for taking part in the research.

Participants were aged between 23 and 39, with a median age of 29. All were unemployed, and the majority lived in areas of deprivation. Five participants were first-time parents, seven had resident older children and seven had non-resident older children (older children were aged between 2 and 19). At the time of the first interview, all participants were engaged with drugs services and prescribed opioids. This was mostly methadone, though one participant was prescribed buprenorphine, and one dihydrocodeine. During the course of the research, several participants' prescriptions altered, and in two cases ceased. Participants reported a range of experiences with drug use. While some presented themselves as being engaged with drug treatment and prescribed opioid-substitutes for some time (up to 13 years); others had only recently engaged, or re-engaged with drug treatment. Most participants reported a history of polydrug use including prescribed and illicit benzodiazepines, cocaine and crack cocaine, cannabis, amphetamines, ecstasy, illicit opioids and mephedrone. Some reported on-going illicit drug use (and 'relapse') during the study period, primarily using illicit opioids and benzodiazepines. Problematic alcohol use was also described by participants; with two women reporting this during their pregnancy. All participants smoked cigarettes, ranging from five to thirty per day.

Research context

Although there are UK clinical guidelines on the use of OST (Department of Health, 2007), practice and policy varies geographically within the UK, and this is the case with OST during pregnancy also. A recent survey reports that service provision for opioid dependent pregnant women in England and Wales is generally high, but that variations in practice are evident, particularly in approaches to methadone prescribing (Perez-Montejano et al., 2011). This was evident within our sample, with eight participants prescribed OST by their general practitioner at the time of their first interview, and the other eleven prescribed by specialist drug treatment services run by the NHS. This included three participants who were managed by a specialist multi-agency support service for pregnant drug and alcohol users. In South East Scotland, OST is dispensed by community pharmacists; this can involve either 'supervised consumption' on the premises or 'take home' doses on a daily, three-times weekly, twice-weekly or weekly dispensing regime, depending on the needs and social circumstances of the drug user and how 'stable' they are perceived to be. Random drug-testing is advocated to monitor illicit drug use; and 'flexible' OST dosages are provided where the user is maintained, reduced or increased depending on service user preference, as well as how well they are seen to be responding to treatment and abstaining from illicit use. Within our sample, some participants reported being tested weekly, with others tested less often.

Data generation

Altogether, 45 interviews were carried out, largely by AC, though some were conducted by AW (5) and GM (3). The interviews were semi-structured, with questions addressing participants' current and past drug use, social background and history, socio-economic circumstances, relationships and social support, experiences of parenting, views on parenting needs, and experiences with services, with a particular focus on parenting support. Additional questions explored participants'

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understandings about parenting, what made a 'good' or 'bad' parent, and how far drug use might impact (or not) on individuals' ability to parent effectively. Interviews lasted between 1-2 hours and were conducted in NHS premises, participants' homes, and some in community centres or cafes. Interviews were transcribed, anonymised and participants given pseudonyms.

Analysis

A sociologically informed, narrative approach to analysis was taken (McCormack, 2004), focusing upon the ways in which parents accounted for their use of OST within the context of pregnancy and parenting, and their experiences of parenting support services. This involved detailed reading of the transcripts by all co-authors, and thematic coding by AC and AW. Coding was facilitated by the use of NVivo software, allowing us to better manage the interview transcripts. The analysis presented here is based on a focused analysis of a content code that included all interview-talk about OST. Text coded as being about OST was subsequently sub-coded, with a focus upon the different ways that participants accounted for OST. We took a comprehensive approach to the data, whereby we included all cases in our analysis, along with deviant case analysis – highlighting those cases that did not fit with the others in terms of how OST was accounted for (Silverman, 2005: 214-5). Comparative analysis was used to further interrogate the data set. We compared antenatal and postnatal accounts, male and female accounts, and accounts which described different OST management strategies e.g. maintenance prescribing versus reduction and detoxification regimes. The accounts of participants were not taken to represent the 'truth' of what they did or did not do, rather we focused on the way the accounts were framed (Barnard, 2005). Such an approach allows an acknowledgement of the social and cultural construction of drug use and parenthood as well as highlighting the importance of the research interview as a site where accounts of these contested issues are co-produced (Radcliffe, 2011; Rhodes et al., 2010).

Ethics

Ethical approval for the project was granted by the local NHS Research Ethics Committee. All participants volunteered to take part in the research and throughout the project, research team members remained attentive to the sensitive nature of the topic and potential concerns for participants in respect of confidentiality and child protection issues.

Findings

The parents' narratives characterised OST as both a facilitator and barrier to normal parenthood and through their accounts they sought to reconcile their status as drug dependent alongside a view of themselves as a 'good enough' parent. Suffusing these overarching narratives were three key themes: first, the material nature of OST, including its status as a substance and its embodied impact on mother and baby (Fraser & valentine, 2008); second, the wider structures surrounding participants' engagement in OST, including prescribing practices, relationships with health care and social workers; and thirdly, the highly charged discourses about the stigmatising nature of being a parent whilst 'on drugs' (including OST).

OST as a facilitator of 'normal' parenthood

Many participants' accounts suggested that OST helped them to engage in 'normal' family life by: enabling them to manage their opioid dependence, and reduce the risks and harms associated with drug use; helping them to 'prove' their worth, or suitability as a parent, to social services and retain

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custody of their children; and countering – to some extent – the stigmatising identity of a being a drug-using parent, by emphasising their orientation towards ‘stabilising’ or reducing their use of prescribed opioids and their avoidance of heroin.

I sort of stopped buying the heroin and started buying methadone fae somebody and got myself stable on the 20 mls when I found oot I was pregnant. I was like that, I would rather one or the other, methadone is sort of the lesser evil of the two. (Caitlin, antenatal)¹

Caitlin’s account positioned herself as able to take control of her use of opioids in response to her pregnancy, by using illicit methadone whilst waiting for a referral to drug treatment. Once prescribed methadone, she indicated that she began to reduce her dosage, planning to become entirely abstinent before her baby was born. Previous research has also found parents have justified their use of OST by framing it as less harmful than heroin (Banwell, 2003; Hogan & Higgins, 2001; Richter & Bammer, 2000). Our findings highlight that an individual’s *practice* of OST can also be a way of constructing a narrative of active engagement in preparing for or practicing parenthood. For instance, Alison’s narrative suggested that pregnancy spurred her into ceasing use of heroin and engaging with services:

The first thing I had to do [upon discovering pregnancy] was to get on a prescription as soon as possible. (Alison, 3 months postnatal)

Alison suggested a key benefit of using prescribed methadone was that it enabled her to leave the sex industry, which had previously supported her use of heroin, allowing her to have what she termed a ‘normal’ life. Others spoke of OST improving their finances and enabling them to spend more time with children, instead of spending time procuring illicit drugs and mixing with deviant peers:

[OST] keeps you away fae everybody [...] I dinnae have to worry aboot the money side of things, which is massive. I dinnae have to worry aboot going oot to get drugs ... all that time involved ... it can take up a whole day to find your drugs, to get sorted Until you’ve got that in you, you’re no’ feeling great, so [OST] just takes all that worry away fae you, and what else have you got? You’ve just got your kids (Bronwyn, 3 months postnatal)

Participants often indicated a hierarchy of ‘acceptable’ and ‘unacceptable’ drug use, with parents who were injecting heroin framed as the most problematic:

It just gets me upset because there's so many people that have got children out there, and they're injecting and their bairns are out with nae shoes on and they've got their bairns, and me and Craig's no’ got ours [referring to older children being taken into care]. (Cheryl, antenatal)

¹ We have preserved dialect in the interview extracts. ‘Frae’ or ‘fae’ = from; ‘bairn’ = child; ‘nae’ = no or not; ‘mair’ = more; ‘dinnae’ = don’t/do not; ‘cannae’ = cannot; ‘wi’ = with; ‘daein’ = doing

Cheryl's narrative argued that health and social services were unjust and ineffective: allowing more neglectful drug-using parents to retain custody of their children, whilst remaining highly suspicious of Cheryl's own parenting capacity, despite the apparent 'stability' of her drug use. That she and her partner had abstained from illicit drug use for a number of years should, Cheryl argued, be seen as evidence of their readiness to parent their children. Thus, the narratives of participants who had been prescribed OST for long periods of time maintained the centrality of remaining free of illicit drugs. Stuart had been prescribed OST for over ten years, and when asked about his experiences of parenting, and preparation for the new baby, his account focused upon his drug use:

AC: And what kind of things can help you to become [a] good enough [parent]?

Stuart: To carry on the way I'm going the now, staying drug free, keep coming [off] methadone.

Like Stuart, other participants emphasised their use of OST in answer to questions about parenting. These accounts framed abstinence from illicit drugs; and *either stability or reduction* of OST dosage as an important marker of parenting capacity and being a 'good enough' parent. The concept of 'good enough' parenting is taken from parenting policy and research (Hoghughy & Speight, 1998). The term was not used spontaneously by participants and rarely by interviewers; more commonly, participants framed their accounts of parenting capacity around concepts of 'good' (acceptable) and 'bad' (unacceptable) parenting .

Accounting for OST during pregnancy was potentially fraught, with most participants indicating at least some awareness that babies born to drug-using mothers could be affected by neonatal abstinence syndrome (NAS). The position of being pregnant whilst using OST was justified by emphasising the importance of maintaining 'stability; in order to lessen pregnancy risks (particularly stillbirth), or by indicating a resolve to reduce their dosage, based on a perception that lower opioid doses minimise the risk of NAS. This was the case for most of the women we spoke to, but similar narratives were used by the two men who had opioid-dependent partners. Michael, for instance said that his partner was "coming down, she needs to come [down] - the time roundabout when the baby's due she should be down to fifty ml". In most cases, either remaining stable or reducing OST during pregnancy was framed as being the 'best thing' for the baby:

It [remaining on methadone] didn't sit too well with me at all, but they said that the amount of stress and pressure it [reducing] put on me would in turn affect my baby and [...] do you know what I mean? So, yeah, it didn't sit very well with me but they had said in the long run it would kind of probably be best for me and the baby. (Elise, antenatal)

Elise described being reassured (and relieved) that her health-care workers agreed it was better for her and her baby if she remained on a stable dose. Elise's account oriented her use of OST as supporting her attempts to do 'the best thing' for her baby, whilst affirming the problematic nature of her status as a 'drug-using mother' and emphasising her discomfort with the situation. Elise framed the 'risk' of detoxification (and relapse) as more dangerous than the 'risk' of 'stable' drug use on OST.

Six female participants, including Alison and Caitlin, reported using heroin during pregnancy. In most of these cases, 'stabilising' their drug use by getting a prescription for methadone, and ceasing illicit opioid use was described as vitally important in preparing for parenthood. While men also reported striving to stabilise or reduce their opioid use via OST, women's accounts of doing this were necessarily more highly charged: being centred on concerns about neonatal abstinence syndrome (NAS) and the direct effects of maternal illicit drug use *in utero*. Nevertheless, both men and women in our study emphasised their own agency in seeking or reducing OST and this served to highlight their active attempt to be a 'good parent':

My baby will be here in another [few] weeks, I don't want...I mean I'm going to ask her [drug worker] to drop it down to 20 ml. This week I'm going to phone up and say look, can you drop it down to 20. (Paul, antenatal)

For women, reduction of OST was framed as an important way in which mothers could improve outcomes for the baby and themselves, and reduce the chance that their baby would experience severe neonatal withdrawal symptoms.

The doctor wanted me to stall at 50 [ml methadone] but I took it to 45 just to make sure because [GP] says it's really unlikely that a baby will withdraw if you're on 50 or less. (Nicola, antenatal)

Particularly in the antenatal interview, almost all women (with just two exceptions) indicated that they had reduced, were reducing, or *hoped* to reduce their prescribed opioids in the near future. This was a key way in which the problematic nature of OST was reconciled with their current or impending motherhood. However, more broadly a stated commitment to reducing OST at some point was an important means through which both male and female participants could use their engagement in OST to frame an account of themselves as a 'good' drug-using parent, drawing as it were on notions of 'recovery' and the good 'motivated' drug user. Of the five men in the sample, three reported reducing their dosage of OST during their partners' pregnancy. Thus, in the research interview, participants of either gender highlighted their awareness that being opioid dependent did not fit with mainstream notions of ideal parenthood, but marked themselves as responsible parents by affirming their future, or current, plans to reduce and come off drugs (opioids at least).

The strength of commitment to reduction of OST varied over the course of the research, with different life events implicated in making reduction more or less possible or desirable. Although most female participants emphasised reduction of their dosage of OST prior to their baby's birth, none described becoming entirely abstinent in the antenatal period. Indeed, in the first postnatal interview (2-4 months), most participants who had been reducing antenatally maintained or increased their OST dosage. The time immediately following the birth of a baby was framed as stressful, with continued reduction representing too much extra pressure. In some cases, participants indicated that this view was endorsed by health care professionals:

I asked the doctor once about reducing and he said it's not the right time to reduce just now because I just had the baby (Hazel, 2 months postnatal).

Additionally, postnatally the risk of maternal drug use causing NAS had passed. Nicola, who had reduced from 120 ml methadone to 45 ml during pregnancy, stopped reducing in her third trimester and remained on the same dose at 3 months postnatal. She suggested that as she was breastfeeding it was better for her to remain on the same dose of methadone so that her baby (who she felt was suffering from NAS) continued to benefit from the drug:

[I'm] not ready to start stopping anything yet, she needs it for the milk [...] so we need to do it really slowly. But I think because I have to deal with her on my own I don't want to be going through not feeling well, so I'm not in a hurry to do it yet (Nicola, 3 months postnatal)

Nicola's account refers to the importance of support networks: like most of the women we spoke with, she was primarily responsible for the care of her baby with little input from her on-off partner or family. Only one participant (Melanie) became and remained abstinent postnatally, and it may be significant that she lived with supportive and highly involved parents, whereas all other participants lived independently. This highlights the importance of social and interpersonal contexts in shaping individuals' use of OST and, indeed, other opioids.

By the time of the final postnatal interview (held between 6 and 11 months postnatal) three participants had relapsed and used heroin, all of whom had previously been reducing their use of OST. In each of these cases, participants' accounts continued to focus upon their (renewed) commitment to remaining stable on OST, and, one day, becoming abstinent:

I absolutely hate myself for it [referring to her relapse], but it's done now, so I have to stop thinking about the past. I just hope that I can honestly stop it like once I come off this [subutex] and never go back to it [heroin], but I think I will [stop] (Carrie, 11 months postnatal)

Participants frequently talked about the importance of providing 'clean' drug tests as a method of demonstrating their commitment to being responsible parents. This reflects the importance that parents indicated health and social services were placing on drug test results as a marker of 'stability' and parental capacity. Having a baby that did not have severe neonatal withdrawal symptoms, engaging and 'complying' with OST regimes, and providing 'clean' drug tests were each presented as evidence that a parent could be 'good enough' to look after their children:

As long as the people at the core group can see that I'm clean hopefully they'll feel more confident about taking her off the [child protection] list. (Elise, 4 months postnatal)

Fear of child protection interventions was an important aspect of many participants' justification of their use of OST. These accounts suggested that participants were compelled to engage in OST in order to secure or retain custody of their baby. For Paul this was a particularly clear feature of his account, as he described being denied access to his baby following a relapse, with limited access only granted once he had re-engaged with drugs services:

Well, it come to the point where I was just, I was doing all that [engaging with OST], like I'm still on a methadone programme and, [...] I was giving clean samples and all that [...] And so

they said, yeah, he's doing okay and that. And he can have access to his [child] now. (Paul, 6 months postnatal)

Paul said that he resented being on methadone (suggesting it was replacing one addiction – to heroin – with another), but indicated that he had to continue with OST in order to be allowed to see his child.

Participants who had been engaged with OST for some time prior to the pregnancy also reported anxiety about the possibility of losing custody of their baby. Cheryl, for instance, presented herself as having been 'stable' on OST for several years but despite this expressed concern in her antenatal interview about being allowed custody of her baby when it was born: "it's [not being granted custody] always at the back of my mind". Such accounts demonstrate that once an individual is engaged in OST, 'normal family life' can still be difficult to achieve, and their status as a 'good enough' parent remains precarious. For some, the antenatal interview was fraught with anxiety about child protection intervention, with any excitement about impending parenthood tinged with concern that they might not be allowed a 'chance' to parent their baby. Thus, participants' accounts indicated that for opioid dependent parents, being (seen to be) 'stable' on OST was an important prerequisite for their being allowed to parent at all.

OST as a barrier to 'normal family life'

OST was described as being a barrier to 'normal family life' in three key ways. Some participants emphasised the ways in which the physical effects of opioid dependence, including withdrawals impacted on their daily routines. Being engaged in OST was tied up with being labelled a 'drug user'; this entailed intensive use of services that were frequently noted to impact negatively on family life. Finally, broader discourse about OST, and the particular stigma attached to methadone was highlighted.

While some participants emphasised that their use of OST carried no particular ill-effects, others highlighted problematic physical repercussions of OST, and continued dependence on opioids. For instance, Russell said that "methadone gives you a bit of a, kind of, fuzzy feeling, like, it's hard to describe, whereas the Subutex doesn't do that, it keeps you more normal", referring to an (initial) preference for buprenorphine over methadone. However, in both of his postnatal interviews, Russell's orientation towards buprenorphine had become more ambivalent; he described struggling "constantly" with physical symptoms of withdrawal and felt unable to cease his use of OST. Leading from this, in his final interview Russell reflected upon and challenged the ideal of abstinence as the primary outcome of drug treatment:

My mum's got tons of tablets for arthritis type stuff that she has to take every day, [...] she's going to be on them forever, so, should I just accept it [being on OST indefinitely] like it's, you know, like that, or should I not accept... (Russell, 6 months postnatal)

Other participants similarly constructed accounts of their embodied experiences of OST around a desire to feel normal:

It's no right having to wait to get medicine to feel normal, I cannae be bothered wi' that crap any mair, I just want to be normal. (Nicola, antenatal)

In suggesting it is not *right* to need medicine to feel normal, Nicola's account emphasises the morally charged discourse around drug dependence more generally. Participants also talked about how they managed the physical effects of OST around their parenting responsibilities. Nicola and Carrie, for instance, talked about ensuring they took their methadone before their children woke up, in order to avoid having to look after children whilst waiting for the drug to 'kick in'. This process was framed as a daily, embodied reminder that, although ostensibly engaging in 'normal' family life, participants did not experience themselves as completely normal, because of continued opioid dependence and reliance on OST:

I'm glad [older child] doesnae wake up till that time because I always usually set my reminder on my phone to take my meth. I'm alright like, but see, when I wake up sometimes and I've just ... it takes about an hour, maybe an hour and a half for my meth to kick in [...] it's really sad, I don't, ... I was [crying] all the night, I just ... I don't remember what it's like to wake up [normal] (Carrie, antenatal)

Managing dependence on OST was noted as a problematic aspect of life by parents, particularly in the postnatal interviews, or when participants had older children as concerns arose about 'visibility' of parental addiction (Rhodes, et al., 2010; Richter & Bammer, 2000). Visiting the chemist to pick up prescriptions was a particularly contentious issue. Some participants suggested that taking children to the pharmacy was utterly unacceptable (and the marker of a 'bad' drug-using parent); while others – generally those with less social support, and thus fewer options – talked about the discomfort they faced when taking their children with them to pick up or consume prescriptions for OST.

I've ta'en her [older child] to the chemist with me a couple o' times, if [partner's] no' been well and that, and I dinnae like daein it cos I'm still on supervised [consumption of methadone]. But she's just, "Ah, mum, get your medicine, are you all better now?" But it's no' something I like daein in front of her, but sometimes I've got nae choice but to take her to the chemist wi' me. (Caitlin, 10 months postnatal)

Reflecting other research, participants tended to suggest that it was important that evidence of drug use and dependence, including OST, be concealed from children where possible (Hogan, 2003; Houmoller et al., 2011; Rhodes et al., 2010; Richter & Bammer, 2000). Having to take children to the pharmacy to acquire or consume methadone generated situations where this concealment was more difficult. Additionally, and again paralleling findings elsewhere (Fraser, 2006: 198), participants' accounts suggested that the pharmacy represented a context where their problematic status as a 'drug-using parent' could be discovered by others:

"You get folk looking at you, [...] whether I've got [older child] wi' me or no', so it's just, "There's the junkie, look at her"" (Caitlin, 10 months postnatal).

Another way in which using OST impacted on family life was the concomitant requirement that the drug dependent parent attend a variety of appointments with health and social care professionals. While some participants described the relationships they had with these professionals as being extremely supportive, in most cases, the number of appointments participants were required to keep was described as excessive: "I had an appointment nearly every day, which was quite hard" (Carrie, antenatal). If participants struggled to keep to all of their appointments, the consequences were portrayed as severe. Iona suggested that her failure to keep appointments was being given as the main reason she would be unable to have custody of her baby. Similarly, Darren's narrative angrily described the consequences he and his drug dependent partner faced if they missed appointments, or failed to pick up their prescriptions:

Now, things like that, to be able to have your [child] taken off you when everybody's saying, the social work and that, you're excellent parents, no question, never been seen taking drugs or anything like that. For lateness, missing a prescription appointment or missing your prescription, that ... being able to adopt your [child], that is disgusting. (Darren, antenatal)

Darren's account was particularly antagonistic regarding his relationship with services. He framed himself and his partner as extremely responsible parents, who were being wronged by the structural constraints of OST, such as toxicology screening, opioid prescribing restrictions, and frequent appointments with a range of services. Unlike Darren and Michael, who had drug-dependent partners, the other three men (whose partners did not use drugs) in this study described much less scrutiny from services in their antenatal interviews. However, in two of these cases (Paul, Stuart) services became more involved in the postnatal period.

Participants also highlighted the on-going stigma they faced, and the ever present potential that they might be labelled a 'junkie (parent)' even after ceasing illicit opioid use and engaging in OST:

Yeah, you definitely get judged, even like with methadone, like the people in my street, I think some of them know that we're on the methadone programme, you can see the way they look at you and stuff, ken, just a junkie. (Carol, 3 months postnatal)

Similar issues were raised by other participants, and for some this was given as a primary reason for wanting to become abstinent. Carrie, for instance, who reported that both a neighbour and an ex-partner had referred to her as a 'junkie' emphasised her concern that her children not be adversely affected by such labelling: "I don't want her going to nursery and folk...or school and folk calling her, your mum's a junkie and that. That was one of the main reasons I wanted to stop."

Discussion

Parents' accounts of parenting, parenting support and OST were complex, reflecting the difficult moral terrain of both parenthood and drug use (Banwell, 2003; Reid et al., 2008). All parents indicated some awareness that being opioid dependent and engaged in OST as a parent was an undesirable, if not unacceptable, position to be in. While some parents' narratives strongly endorsed the view that parenting in the context of problem drug use, including OST, was incompatible; others

challenged this interpretation. In either case, participants had to account for their own use of OST and their role as a parent; the ways in which they approached this varied.

For some, OST was framed as an important prerequisite to being able to parent at all: this method of accounting framed illicit drug use and parenthood as utterly unacceptable, with OST a 'lesser evil'. These parents were involved with numerous health and social services and were subject to high degrees of monitoring and surveillance. They indicated a keen awareness that if they were not (seen to be) engaging in OST, and relapsed into illicit drug use, they risked (or had actually experienced) losing custody of their children. These parents' narratives framed engagement in OST as centrally important to their being able to maintain the role of a 'full' active and involved parent.

However, in the majority of cases, participants also highlighted negative impacts of OST on their attempts to maintain a 'normal family life'. We have argued that these negative impacts can be seen to relate to the substances involved in OST; the structures of the services entailed by OST; and finally the impact of wider (stigmatising) discourses regarding drug-using parents. It is important that services and policy makers recognise the ambivalent nature of parenting whilst using OST. Although ostensibly 'in recovery', the narratives of many of the participants we spoke with were rarely optimistic or hopeful: there was a keen awareness that their identity as a 'good parent' was at risk as long as they continued to use opioids of any kind.

There are potentially serious consequences of the idealisation of abstinence and sobriety, especially when such a view is clearly reflected in health and social care policy and practices (Rhodes et al., 2010): participants in this study reported concealing illicit drug use from services, relapsing following attempts to reduce OST dosage and become abstinent, and attempting to reduce rapidly during pregnancy. Nevertheless, policy in the UK is, if anything, wed to the notion of recovery and abstinence as a desirable, realistic and achievable goal for most, if not all, problem drug users (HM Government, 2010; The Scottish Government, 2008). We would suggest that given this policy context, along with fears around child welfare with regard to drug-using parents, it may be especially challenging for parents to have 'open' conversations about parenting needs, risk, and drug use as suggested by Rhodes et al (2010: 1496). There is a need for further reflection on the interactions between policies and practices designed to support child welfare, harm reduction and the promotion of abstinence and recovery, and to consider the implications of these for both parents and children.

Participants' descriptions of the problems entailed by being engaged in OST were shaped by negative, stigmatising attitudes known to be held towards drug-using parents. These accounts often referred to the discomfort of not feeling 'normal'. This was simultaneously a bodily, physical symptom of withdrawal, as well as a painful reminder that the parent was not 'actually' normal, since they remained dependent on and engaged with OST. Similarly, the need to engage with various services as a result of their drug dependent status and use of OST, and the severe repercussions if they did not comply, were further – painful – reminders of their 'abnormal' status as a parent. Thus, as others have noted, the substances and structures that comprise OST are made all the more difficult because of wider attitudes towards problem drug use (Bourgois, 2000; Fraser & valentine, 2008; Rhodes et al., 2010; valentine, 2007).

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The above offers support to valentine's (2007) arguments regarding the ambiguous and complex nature of OST – that it is not merely 'negative' or 'positive' but rather embodies qualities from both depending upon the context. This is certainly evident in accounts of negotiating and managing OST alongside parenthood. OST is framed as generating positive effects by enabling (some) parents to better manage their drug dependence and move away from 'deviant' lifestyles. Simultaneously, accounts suggest more negative and uncomfortable connotations, with parents continuing to inhabit a liminal position where they are not yet fully 'normal', and the substances, structures and stigma involved in and associated with OST are a frequent reminder of this.

Finally, some of the limitations of our study are worth noting. The research was based on a small group of opioid dependent parents (mainly mothers) who were engaged in OST programmes, primarily orientated towards maintenance prescribing of methadone and delivered within general practice as well as specialist drug treatment settings. All our participants were recruited from one geographical area in Scotland. Thus our sample may not be typical of drug-using parents living elsewhere, including other areas of Scotland. The accounts of parents in our study can be seen to reflect local policies and practices surrounding OST and may not reflect parental experiences of OST in other areas where drug treatment and parenting support services may be differently orientated. The parents in our study all typically used a variety of other drugs, but in an area where the primary 'drugs of choice', other than opioids, are sedatives (primarily prescribed or illicit diazepam). Thus, concerns over stimulant drug use (e.g. cocaine, crack cocaine or amphetamines) which are far more prevalent in some areas, were not a dominant feature in this study. Nevertheless, we would argue that the child protection agenda now dominates the field of parental drug use, and all drug-dependent parents need to account for their drug-taking behaviour (prescribed or illicit). Examining the ways in which they do this sheds light on the challenges that they face, and equally the challenges that service providers face in working constructively with this group of parents and families.

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